DHS

Uganda

Demographic and Health Survey 1988/1989

SUMMARY REPORT

USAID

This report summarizes the findings of the 1988/1989 Demographic and Health Survey of Uganda, conducted by the Ministry of Health in Uganda in collaboration with the Ministry of Planning and Economic Development and Makerere University. The Institute for Resource Development provided funding and technical assistance. Editorial and production support for this report was provided by the IMPACT project of the Population Reference Bureau.

The Uganda survey is part of the worldwide Demographic and Health Surveys (DHS) programme, which is designed to collect data on fertility, family planning, and maternal and child health. Additional information on the Uganda survey may be obtained from: Dr. Emmanuel M. Kaijuka, Ministry of Health, P.O. Box 8, Entebbe, Uganda (Telephone: 042-20201; Telex: 61372 HEALTH UGA) or the Ministry of Planning, Statistics Division, P.O. Box 13, Entebbe, Uganda. Additional information about the DHS programme may be obtained by writing to: DHS, Institute for Resource Development/Macro Systems, Inc., 8850 Stanford Boulevard, Suite 4000, Columbia, MD 21045, U.S.A. (Telex 87775).

July 1990

EXECUTIVE SUMMARY

The 1988/1989 Uganda Demographic and Health Survey (UDHS) identified several important trends:

- Fertility has remained unchanged for the past 15 years;
- Child mortality rates have declined slightly in the past five years; and
- Women continue to marry and start their families at an early age.

Fertility remains high. At current rates, women are having an average of more than seven children. Child mortality is also high; one child in six dies before his or her fifth birthday.

Major survey findings include:

- *Fertility Desires:* On average, women would like to have about one child fewer than they are now having.

MOH

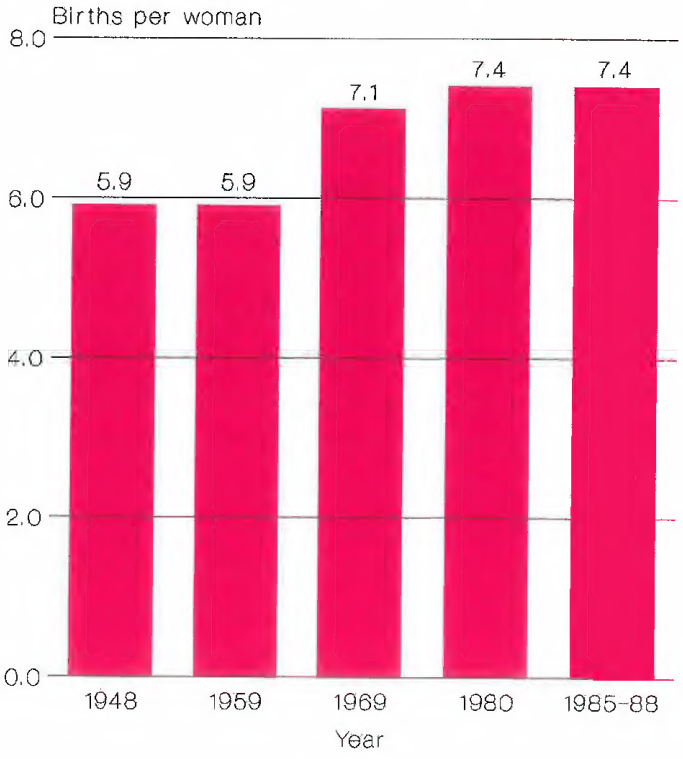
- *Potential Demand for Family Planning:* More than half of all married women would like to limit or space births.
- *Contraceptive Use:* Only 5 percent of married women are using a contraceptive method, and only 3 percent use modern contraceptive methods.
- *AIDS Prevention:* Condom use is negligible, suggesting that the method is not widely used for AIDS prevention among the general population.
- *Maternity Care:* The majority of births are assisted by untrained people or are unattended, although most women reported at least one prenatal-care visit.
- *Child Health:* Diarrhoea, fever and respiratory problems are common illnesses among children under age five; only 14 percent of children with diarrhoea were treated with oral rehydration salts, an inexpensive treatment which can often prevent death from dehydration.
- *Child Nutrition:* Forty-five percent of the children under age five are considered stunted, or short for their age in comparison with an international reference population. Stunting is a sign of chronic undernutrition.

One important finding of the UDHS is that many women are interested in birthspacing or limitation but lack the necessary information or access to family planning services. One in five married women who are not practising family planning says that she intends to use some form of contraception, mainly modern methods. Demand for modern contraceptive methods could increase in the future, since women under age 30 want smaller families than older women.

BACKGROUND

The 1988/1989 Uganda Demographic and Health Survey (UDHS) provides planners and policy-makers with essential information on fertility, infant and child mortality, maternal and child health care, and family planning and related factors. It was conducted by the Ministry of Health in close collaboration with the Ministry of Planning and Economic Development and Makerere University's Institute of Statistics and Applied Economics and the Geography Department. A sample of 4,730 women age 15-49 was interviewed between September 1988 and February 1989. The sample covered 25 out of 33 districts. Karangara, a 34th district, was created after the survey, but was included in Mpigi district during the survey. Eight northern districts (Apac, Lira, Gulu, Kitgum, Kotido, Kumi, Soroti and Moroto) were not surveyed due to security reasons. Interviews with mothers provided health-related information for more than 4,000 children under age five. Height and weight measurements were taken and analysed for 3,150 children under age five.

Figure 1
PAST AND CURRENT FERTILITY*



* Total fertility rate (average number of children a woman bears in a lifetime at the fertility rates during the period) based on census data for 1948, 1959, 1969 and 1980 and UDHS for 1985-88

UDHS 1988/89

FERTILITY

At current fertility levels, Ugandan women will give birth to an average of more than seven children by the end of their reproductive years (see Figure 1). This fertility rate has remained unchanged for the past 15 years and constitutes an increase from the six-child family average found in the 1948 and 1959 censuses. Nevertheless, the UDHS found that fertility has declined by about one child per woman in urban areas over the past two decades and has been stable in rural areas.

At current fertility rates, women will have more than seven children during their childbearing years.

If current fertility rates continue, women who live in urban areas and those with a higher-level education will have an average of two children fewer than rural women and those with a primary-level or less education. Fertility is lowest in Kampala and highest in the West and South West regions.

Factors Affecting Fertility

Age at Marriage and First Birth

Women who marry at an early age tend to have more children than those who marry later. Half of all Ugandan women age 20-49 were married or in union by the age of 18. Eight percent of the women surveyed

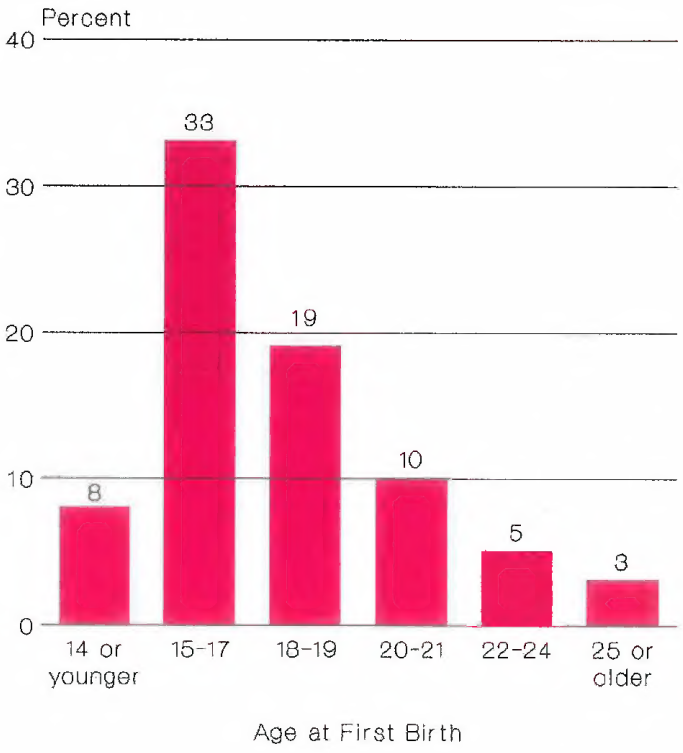
had had a child before reaching the age of 15, and an additional 33 percent gave birth at ages 15-17 (see Figure 2). Half had given birth before age 19. This pattern of early childbearing not only contributes to high fertility, but also can be detrimental to the health of young mothers and their children. Other research has shown that early childbearing is frequently associated with various social and economic problems, including child neglect, poverty and limited educational attainment.

Half of all Ugandan women give birth by the age of 19.

Women in their 20s are marrying slightly later than older women. Women living in urban areas marry about one year later than rural women, and women with a secondary-level education marry about three years later than those with some primary or no education.

One-third of the married women report that their husbands have other wives. The effect of polygyny on fertility is unclear: while some women may have many children in order to obtain a larger share of family property than their co-wives, polygyny also encourages prolonged birthspacing, which would tend to lower lifetime fertility.

Figure 2
AGE AT FIRST BIRTH
(Women 15-49)



UDHS 1988/89

MOH

Breastfeeding and Postpartum Infecundity

Breastfeeding extends the period of natural infecundity following a birth, during which a woman is unlikely to conceive. Ugandan women breastfeed an average of 19 months. Postpartum amenorrhoea — the absence of menstruation that is associated with the period of natural infecundity following a birth — lasts for an average of 13 months.

Taking into account amenorrhoea and postpartum abstinence practices, half of all Ugandan women are not at risk of pregnancy for at least one year following a birth. However, the duration of breastfeeding is lower among urban women and those who are better educated. Also, women under age 30 breastfeed their children for slightly shorter durations than women age 30 and older. These factors suggest a trend toward reduced breastfeeding in the future.

Fertility Desires

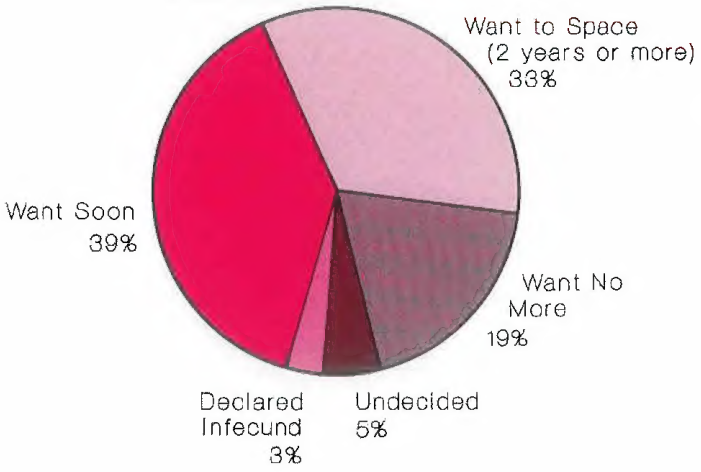
The high level of fertility in Uganda reflects, in part, a desire for large families. When asked how many children they would prefer to have, women gave an average of 6.5 children. Nevertheless, fertility desires may be changing. Women age 15-29 stated they would like to have an average of six children each, compared with the seven children preferred by women age 30-49. Similarly, urban women prefer about one child less than rural women.

Despite their desire for large families, Ugandan women do experience unwanted or mistimed births. Of those children born in the previous year, mothers reported that 5 percent were unwanted and 30 percent were wanted at a later date.

One in five married women wants no more children.

Many women express a desire to control the number and timing of future births. One in five married women does not want any more children, and one in three would like to delay her next birth by at least two years (see Figure 3). More than half of the married women age 40 or older and those who already have six children want no more children. Rural and urban women do not differ greatly in their desire to stop childbearing, and there is little difference according to educational levels, except at the higher level, where a larger proportion of women want to end childbearing.

Figure 3
FERTILITY PREFERENCES
(Married Women 15-49)



UDHS 1988/89

MOH

FAMILY PLANNING

Recognition of Contraceptive Methods

Nearly four in five married women (78%) have heard of at least one modern method of contraception. Among married women, the most widely recognized modern methods are the pill (68%), female sterilisation (63%), injection (41%), and condom (31%). Awareness of modern methods is especially low in the West Nile region, where fewer than one in five married women recognize at least one modern method. Three in five married women have heard of at least one traditional method, mainly periodic abstinence. Despite the awareness of periodic abstinence, only one in 10 women could correctly identify the most fertile period of a woman's cycle (the middle).

Eight in 10 married women have heard of family planning, but only one in 20 is currently using a method.

While most married women (72%) report knowing where to obtain information or services for at least one modern contraceptive method, knowledge of sources

for specific methods is limited. Slightly more than half of the married women know where to obtain female sterilisation or the pill, about one-third know a source for the injection, but only one in five knows a source for the condom or IUD.

Attitudes Toward Family Planning

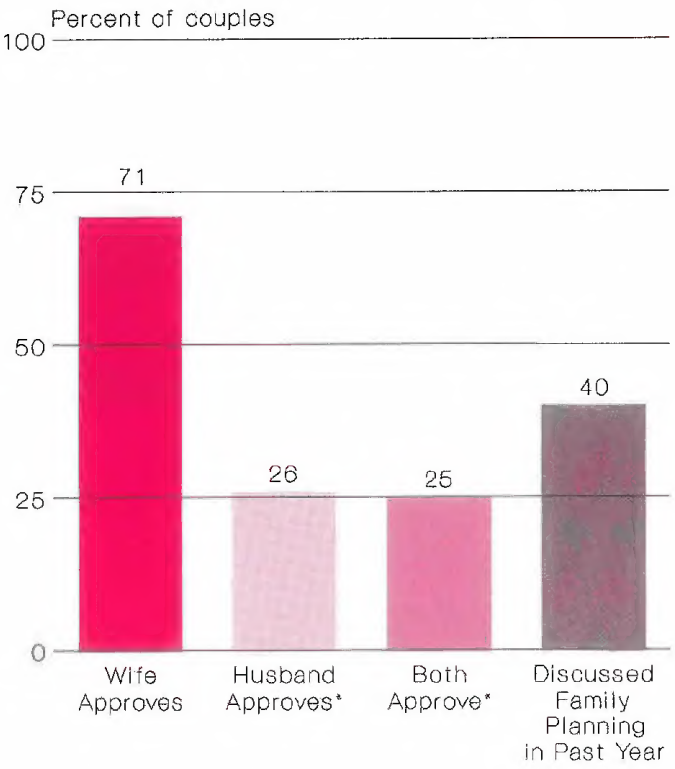
Among married women who have heard of at least one contraceptive method, seven in ten said they approved of couples using a family planning method to prevent pregnancy (see Figure 4). Approval rates were highest among urban women, especially in Kampala, and among those with a primary-level or higher education.

Most couples do not discuss family planning.

When asked about their husbands' attitudes toward contraception, however, 40 percent of the married women said they thought their husbands disapproved, 26 percent said they thought their husbands approved, and 33 percent did not know their husbands' opinions. Only 40 percent of married women said they had spoken with their husbands about family planning in the past year. These findings suggest the need to educate men, as well as women, about family planning.

More than two-thirds of the women surveyed said they approve of the dissemination of family planning information on the radio or in the newspaper. A similar proportion approve of family planning being taught in school.

Figure 4
ATTITUDES TOWARD FAMILY PLANNING
(Married Women 15-49 Knowing a Method)



*According to wife's report

UDHS 1988/89


MOH

Perception of Problems with Contraception

Women who recognized a specific contraceptive method—but who may not have used the method—were asked to name the major problem, if any, regarding its use. A substantial proportion of women cited health concerns as the major problem associated with modern methods, especially the pill (45%), IUD (33%) and injection (32%). The permanency of female and male sterilisation was also commonly mentioned. Lack of effectiveness was cited as a problem for periodic abstinence and withdrawal.

For all methods, between 50 and 70 percent of women said they did not know of any problems or that the method had no problems, suggesting a lack of in-depth knowledge of the methods. Other responses also indicated a lack of knowledge. For example, women cited health concerns in regard to the condom and diaphragm and permanency in reference to the injection.

Contraceptive Use

Fewer than one in four married women have ever practised contraception; most of these women have used periodic abstinence. Only 7 percent have ever used a modern method, and fewer than 1 percent have ever used a condom. This latter finding suggests that

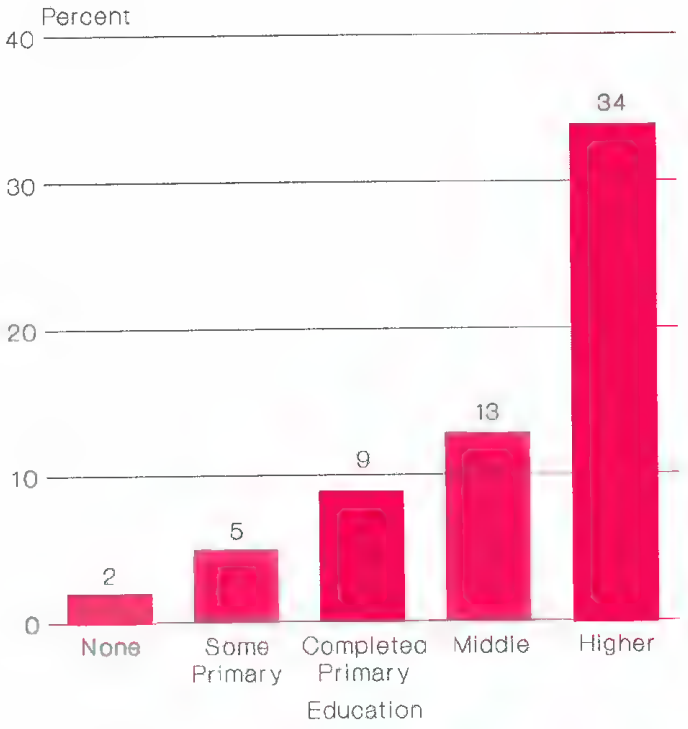
condom use for AIDS prevention is extremely limited among the general population, although it is possible that women using the condom for this purpose omitted mention of it. Also, women may have under-reported condom use in general, since condoms are used by their partners.

Contraceptive use among married women varies greatly by place of residence, from a low of 1 percent in the West Nile region to a high of 25 percent in Kampala.

Only 5 percent of married women are currently using some form of contraception, and only half of them are using a modern method. The most popular methods are periodic abstinence (2%), the pill (1%), and female sterilisation (1%). Use of other methods, including the condom, is negligible.

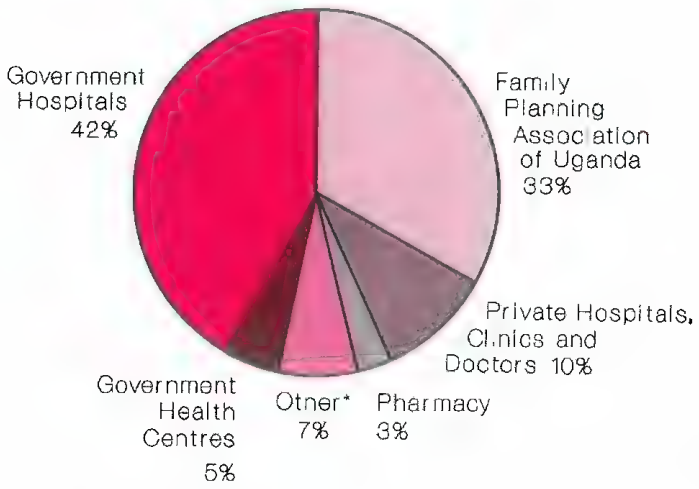
Family planning use varies greatly by area of residence, from 18 percent among urban women to only 4 percent among rural women. Contraceptive prevalence is 25 percent in Kampala, 7 percent in the West region, and 5 percent or below in the other regions surveyed. Similarly, large disparities in contraceptive use are found among women with different educational backgrounds; 34 percent of married women with a higher-level education use contraception, compared with 2 percent of those with no education (see Figure 5).

Figure 5
USE OF FAMILY PLANNING BY EDUCATION
(Married Women 15-49)



UDHS 1988/89

Figure 6
SOURCES OF MODERN FAMILY PLANNING METHODS
(Percent of Women Using Modern Methods)



*Includes church, field worker, mobile clinic, friends and relatives

UDHS 1988/89

Family planning use also increases with family size. Women with four or more living children are more likely to use contraception than those with fewer children. Also, women under age 30 show a growing tendency to use contraception to postpone their first birth or to space subsequent births, indicating some acceptance of family planning for birthspacing purposes.

Family Planning Services

Of those women using modern contraceptives, nearly half obtain their methods from government hospitals and health centres, and one-third from the Family Planning Association of Uganda (FPAU) (see Figure 6). Private doctors, hospitals and clinics as well as pharmacies also provide contraceptives.

Reasons for Non-use of Contraception

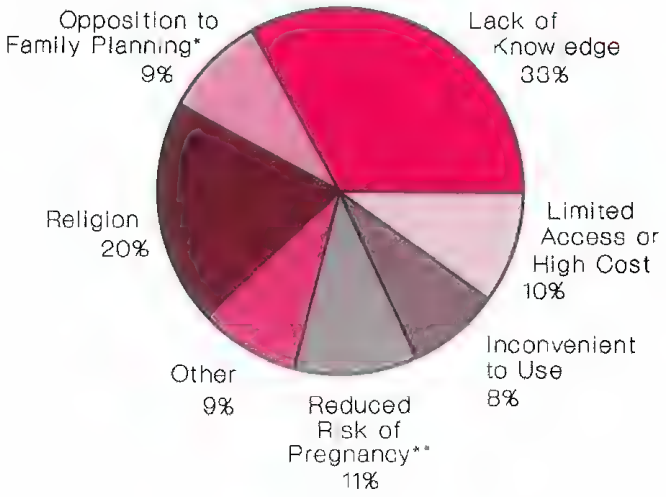
Those women at potential risk of pregnancy (non-pregnant, sexually active non-users) were asked about their attitude toward becoming pregnant in the next few weeks. Half (51%) said that they would be unhappy if they became pregnant, while 44 percent said that they would be happy and the remainder said that it would not matter. Those women who said they would be unhappy were asked why they were not using contraception. More than half of the non-users gave reasons indicating lack of knowledge, limited access or inconvenience (see Figure 7). These problems could be addressed by public education programmes and provision of more accessible services with a wide range of methods.

On the other hand, it should be recognized that a significant proportion of women hold negative views toward family planning. More than one in four non-users cited religion or opposition to family planning as their reason for not using contraception. Some of the concerns underlying these attitudes might be addressed by public education programmes, particularly statements by religious leaders.

Potential Demand for Family Planning Services

More than half of all married women (54%) can be considered potential users of family planning services because they are not using contraception and either do not want to become pregnant soon or do not want any more children. However, only one in four of these women say they intend to use contraception in the future. Thus, only 14 percent of married women are in need of family planning and intend to use it. The majority of women who intend to use contraception plan to do so in the next year. Preferred methods are the pill, injection and periodic abstinence.

Figure 7
REASONS FOR NON-USE OF FAMILY PLANNING
(Women at Risk of Unplanned Pregnancy)



*Includes self, husband or others

**Includes breastfeeding, infrequent sex, menopausal and subfecund

UDHS 1988/89

Figure 8
TRENDS IN CHILD MORTALITY
(1973-1988)

UDHS 1988/89

MATERNAL AND CHILD HEALTH

Infant and Child Mortality

Child mortality rates have fluctuated during the past decade, probably due to the deterioration of the health services during the civil unrest between 1973 and 1982 (see Figure 8). Today, about one in six children dies before his or her fifth birthday.

One in six Ugandan children dies before his or her fifth birthday.

The UDHS findings highlight several factors that are related to child survival:

- *Place of Residence:* Infant mortality rates are only slightly higher in rural areas than in urban areas, but rural children age 1-4 have a substantially higher risk of death than urban children. The highest child mortality rates are found in the West Nile and East regions.
- *Mother's Education:* Children born to mothers with no education are nearly twice as likely to die before their fifth birthday as those whose mothers have a higher-level education.
- *Birthspacing:* Children born less than two years after a previous birth are twice as likely to die before their first birthday as those born four or more years after a previous birth (see Figure 9).

- *Mother's Age:* Children born to mothers under age 20 have a 20 percent higher risk of dying before their fifth birthday than those born to older women.

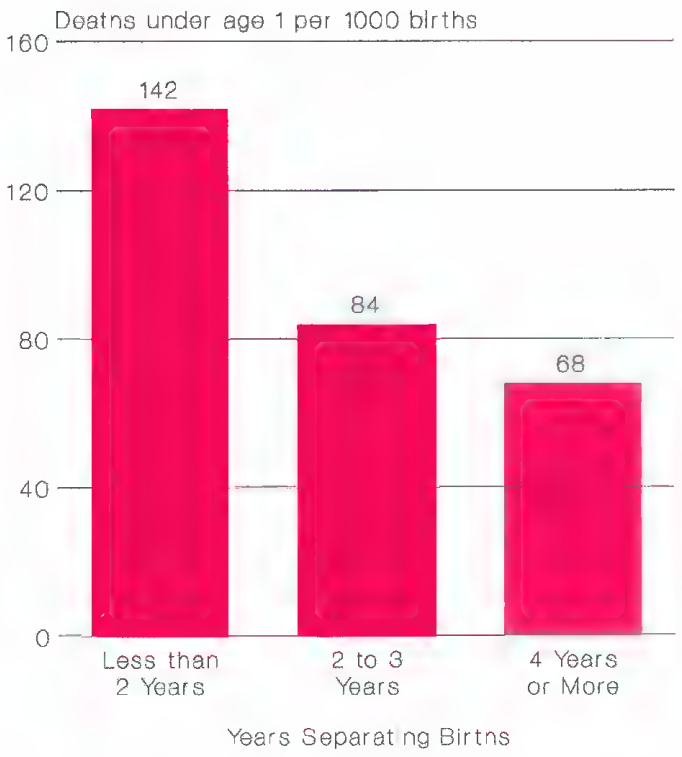
Maternity Care

The care a woman receives during pregnancy can be critical to her child's chance of survival. Mothers of 87 percent of the children born in the five years before the survey reported at least one prenatal care visit, provided by trained nurses, midwives or doctors. Rural women, women in West Nile and West regions, and those with little or no education were less likely than other women to have had prenatal care.

Many infants are still not protected from neonatal tetanus, a highly fatal—but preventable—disease that can strike newborns if the mother has not been immunized against tetanus and if the umbilical cord is not treated in a sterile manner. Mothers of only about half of the births in the five years before the survey reported that they had received at least one tetanus toxoid injection during the pregnancy.

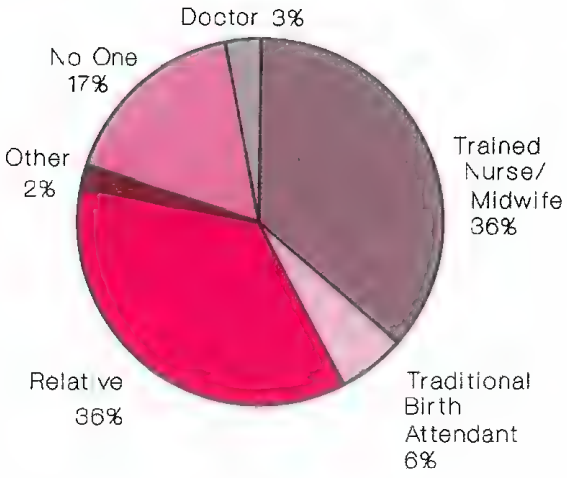
Many women who receive prenatal care are not assisted by a trained attendant at the time of delivery. Thirty-six percent of the births in the five years before the survey were assisted by trained nurses or midwives,

Figure 9
BIRTHSPACING AND INFANT MORTALITY
(1978-1988)



UDHS 1988/89

Figure 10
ASSISTANCE DURING CHILDBIRTH
(Births during the 5 Years before the Survey)



UDHS 1988/89

and only 3 percent by doctors (see Figure 10). Forty-two percent were assisted by untrained people (relatives or traditional birth attendants). Seventeen percent of all births took place with no assistance whatsoever — an alarmingly high figure with serious implications for the health of mothers and newborns. Rural women, those with some primary or no education, and those age 30 or older were more likely to be assisted by untrained people or to give birth alone than urban, more educated, or younger women.

Half of all births take place without medical assistance.

Breastfeeding and Infant Health

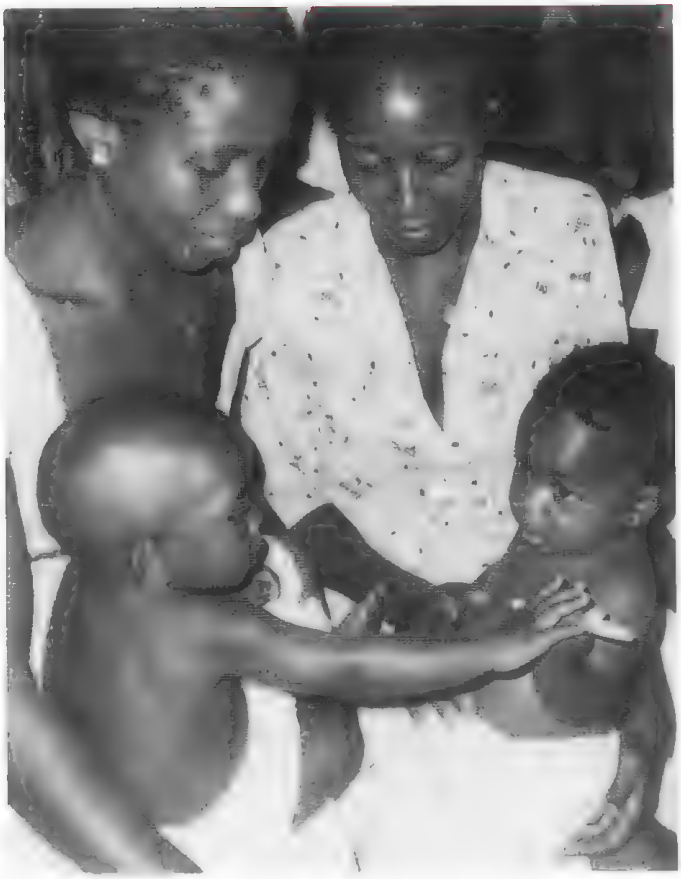
In addition to providing the mother some protection against another pregnancy, breastfeeding is important to child health and development. Nine in 10 of all Ugandan children are breastfed through their first eight months of life; half are breastfed through 19 months of age.

Child Health

Vaccination

Vaccination against the six major childhood diseases — tuberculosis, diphtheria, whooping cough, tetanus, poliomyelitis and measles — is a key intervention to improve child survival rates. Vaccination status could be verified for only half of the children age 12-23 months — those whose mothers could show a health card. Among children in this age group with a health card, 48 percent had been vaccinated against all six childhood diseases. For most vaccines, the coverage is lowest among children living in rural areas or in the West Nile and East regions, and boys are slightly more likely than girls to be vaccinated. Children whose mothers have a middle or higher-level education are more than twice as likely to be fully vaccinated as those whose mothers have no education.

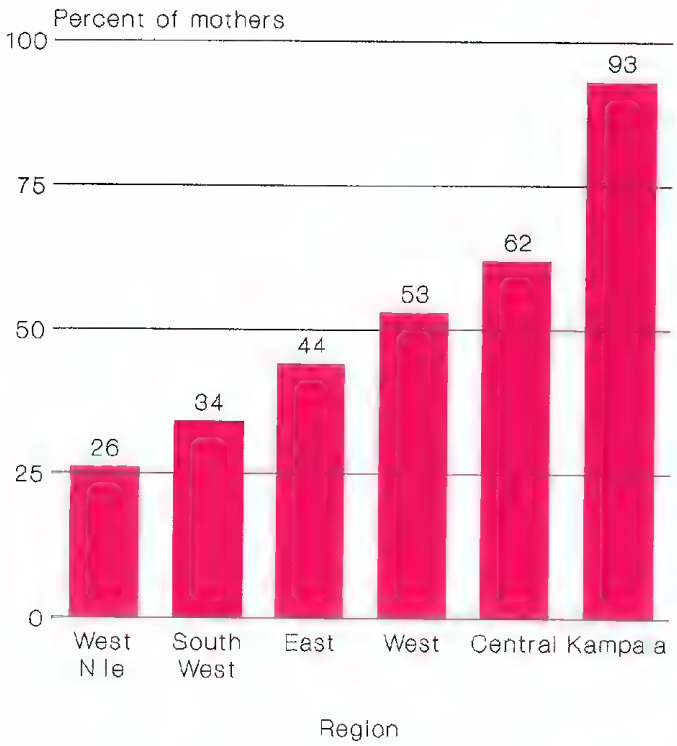
Fewer than half of the children age 12-23 months having a health card are fully vaccinated.



Diarrhoea

Mothers reported that 24 percent of the children under age five had had diarrhoea in the two weeks prior to the survey. Diarrhoea is more common among

Figure 11
KNOWLEDGE OF ORAL REHYDRATION SALTS (ORS) BY REGION
(Mothers of Children Under Age 5)



UDHS 1988/89

children age 6-17 months and those living in rural areas and in the East region than among other children.

Only 14 percent of the children under age five with diarrhoea were treated with oral rehydration salts (ORS), an inexpensive treatment which can often prevent death from dehydration. Half of the mothers of children under age five had heard of Dalozi, specially prepared ORS packets of sugar and salts. Urban women and those living in Kampala were more likely than other women to have heard of the ORS packets (see Figure 11).

Fever

Malaria is evidently common among children in Uganda. Mothers reported that more than two in five

Half of the children age 6-17 months had a fever in the four weeks prior to the survey.

children under age five had had a fever in the four weeks prior to the survey. Children age 6-17 months were more likely to have had fever than younger or older children; half of the children in this age group had had a fever. Fever was more common among children living in rural areas and in the East region than among those living in other areas. More than half of the children with fever were reportedly treated with anti-malarial drugs.

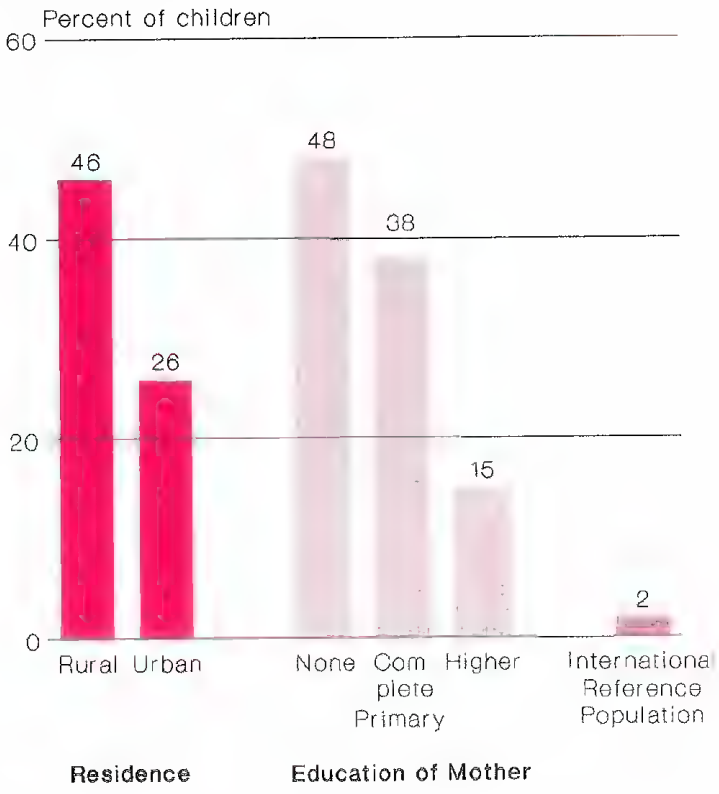
Respiratory Problems

Mothers reported that in the four weeks prior to the survey more than one in five children under age five had had a severe cough or difficult or rapid breathing, a symptom of serious respiratory infections such as pneumonia. Children age 6-23 months and those living in rural areas and in the South West and West Nile regions were more likely than other children to have had a cough. Nearly half of the children with breathing problems were taken to a medical facility.

Nutritional Status of Children

As part of the UDHS, respondents' children under age five were weighed and measured to assess their nutritional status. The study found that 45 percent of these children are stunted — short in relation to their age — compared with an international reference population. Stunting is an indicator of chronic undernutrition. It is more common among boys and children living in rural areas or in the South West and West regions (see Figure 12).

Figure 12
CHRONIC UNDERNUTRITION* BY RESIDENCE AND EDUCATION
(Children Under Age 5)



*Two or more standard deviations below the mean height-for-age for the international reference population

UDHS 1988/89

Children's nutritional status differs markedly according to their mothers' level of education. Children

More than two in five children under age five show signs of chronic undernutrition.

whose mothers have no education are three times more likely to be classified as stunted than those having mothers with higher education. Children who have recently had fever, respiratory infections or diarrhoea are also more likely to be stunted. Not only can such illnesses contribute to undernutrition, but also undernutrition can weaken resistance to disease.

MOH

CONCLUSIONS

The results of the 1988/1989 Uganda Demographic and Health Survey document a need for expanded health and family planning services and for greater public education on these topics. Rural women and children as well as women with little or no education are particularly disadvantaged in terms of health status and use of health services. Most mothers give birth without medical assistance, and many children do not receive medical treatment for common childhood illnesses.

The UDHS findings suggest several specific policies and programmes that could have a major impact on child survival and women's health:

- Providing more extensive medical care during childbirth;
- Educating parents on appropriate medical treatments for diarrhoea, fever and respiratory problems and on the importance of vaccination against the major childhood diseases;
- Developing special programmes to reach rural and less educated women and their children;
- Improving the nutritional status of children through growth monitoring, nutrition education and adequate treatment of diseases; and
- Educating parents on the benefits of childspacing and the range of available contraceptive methods.

A concerted effort will be needed to reduce maternal and child mortality levels substantially.

The UDHS findings suggest that demand for family planning services could increase considerably within the next several years as women's reproductive goals continue to change. The potential demand for family planning services is large: more than half of all married women do not want to become pregnant soon or do not want any more children and yet are not using any form of contraception.

Key areas for family planning programmes include:

- Informing women and men about the advantages and disadvantages of modern contraceptive methods and their correct usage;
- Training health workers to assist clients in making reproductive choices and using contraceptives correctly;
- Encouraging couples to discuss their reproductive goals and attitudes toward family planning; and
- Educating couples on the benefits of postponing their first birth and spacing subsequent births at least two years apart.

Persuading young women to postpone childbearing and space subsequent births could have a major impact on fertility and child mortality.

MOH

FACT SHEET

Ministry of Planning and Economic Development

Population Size (millions, 1988)	15.9
Population Growth Rate (percent, 1969-80)	2.8
Population Doubling Time (years, 1988)	25
Birth Rate (per 1,000 population, 1980)	50
Death Rate (per 1,000 population, 1981)	20

Uganda Demographic and Health Survey 1988/1989

Sample Population

Women 15-49	4,730

Background Characteristics

Percent urban	11.5
Percent with more than primary education[1]	10.3

Marriage and Other Fertility Determinants

Percent currently married	67.3
Percent ever-married	80.5
Median age at first marriage for women 20-49	17.5
Median age at first birth for women 20-49	18.5
Mean length of breastfeeding (in months)[2]	18.6
Mean length of postpartum amenorrhoea (in months)[2]	12.7
Mean length of postpartum abstinence (in months)	24.1

Fertility

Total fertility rate (projected completed family size)[3]	7.3
Mean number of children ever born to women 40-49	7.5
Percent of currently married women who are pregnant	13.0

Desire for Children

Percent of currently married women:	
Wanting no more children	19.4
Wanting to delay next birth at least 2 years	33.4
Mean ideal number of children for women 15-49	6.5
Percent of unwanted births[4]	4.6
Percent of mistimed births[5]	30.1

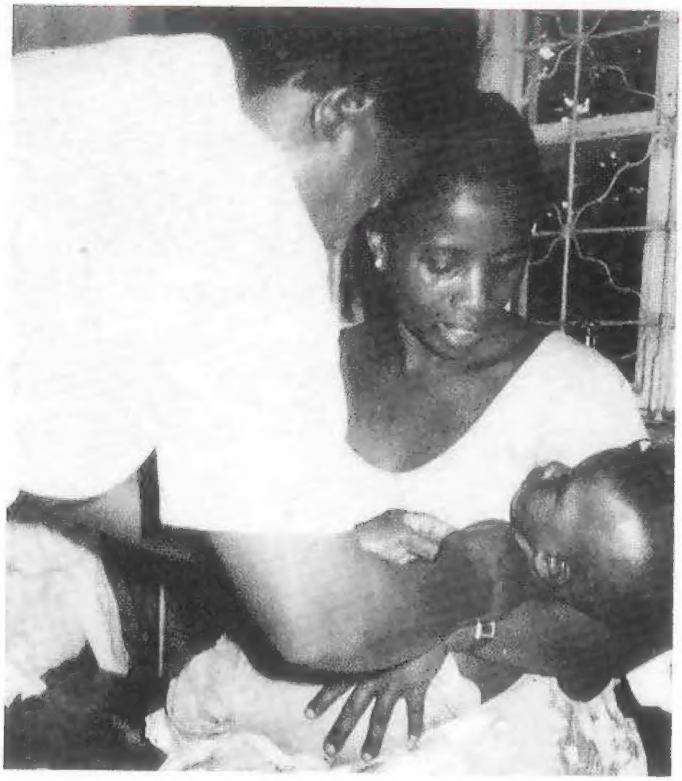
Knowledge and Use of Family Planning

Percent of currently married women:	
Recognizing any modern method	77.9
Knowing source for any modern method	72.3
Ever using any method	21.5
Currently using any method	4.9
Periodic abstinence	1.6
Pill	1.1
Female sterilisation	0.8
Injection	0.4
Withdrawal	0.3
IUD	0.2
Condom	0.0
Other traditional methods	0.4
Percent of modern method users obtaining methods from:	
Government hospital/clinic	46.6
Family Planning Association of Uganda clinic	33.2
Pharmacy	3.1
Private hospital/doctor/clinic	10.2
Church	2.4
Other	4.0

Mortality and Health

Infant mortality rate[6]	101.2
Under five mortality rate[6]	180.4
Percent of mothers of recent births who:[7]	
Received prenatal care during pregnancy	86.7
Received tetanus toxoid injection during pregnancy	55.6
Were assisted at delivery by doctor or trained nurse/ midwife	38.3
Percent of children age 0-1 month breastfed	90.9
Percent of children age 4-5 months breastfed	89.9
Percent of children age 10-11 months breastfed	81.7
Percent of children under five years of age with health cards	44.0
Percent of children age 12-23 months with health cards	49.3
Percent of children age 12-23 months who have had at least one vaccination[8]	71.2
Percent of children age 12-23 months with health cards who have received the following vaccines:	
BCG	98.0
DPT (all three doses)	57.0
Polio (all three doses)	57.4
Measles	71.5
All six vaccines	47.7

continued, next page



MOH

Percent of children under age 5:	
With diarrhoea[9]	24.3
Proportion with diarrhoea given ORS	13.7
With fever[10]	41.4
Proportion with fever reportedly given anti-malarial treatment	57.1
With respiratory problems[11]	22.4
Proportion with respiratory problems consulting medical facility	48.2
Percent of children under age 5 considered moderately or severely chronically undernourished, based on height-for-age	44.5

[1] Six or more years of education; includes those with Junior 2 or higher

[2] Current status estimate based on births within 36 months of the survey

[3] Based on births to women 15-49 years during the period 0-4 years before the survey. This rate differs from the one given in Figure 1 (7.4) because it covers a five-year period, while Figure 1 denotes a three-year period

[4] Percent of births in the 12 months before the survey which were unwanted

[5] Percent of births in the 12 months before the survey which were wanted later

[6] Rates are for the five-year period preceding the survey (approximately 1983-1988)

[7] Based on births occurring during the five years before the survey

[8] Based on mothers' reports

[9] Based on children under age 5 reported by their mothers as having diarrhoea during the two weeks before the survey

[10] Based on children under age 5 reported by their mothers as having fever during the four weeks before the survey

[11] Based on children under age 5 reported by their mothers as having difficulty breathing during the four weeks before the survey